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STATE OF NEVADA
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February 11, 2008

Honorable Henry A. Waxman, Chairman
House of Representatives
Committee on Oversight and Government Reform
2157 Rayburn House Building
Washington DC 20515-6143

Dear Congressman Waxman:

This is in response to your January 16, 2008 letter investigating the Executive Branch's regulatory actions on Medicaid. I have addressed each of the actions individually and provided all the materials/data available from our Division and how these regulatory actions will impact our agency and the Medicaid recipients of Nevada.

Cost Limits for Public Providers (CMS 2258-FC)

This proposed rule made five provisions: (1) to clarify the definition of a public entity; (2) to establish minimum documentation when using a certified public expenditure; (3) limit health care providers operated by governmental providers to reimbursement that does not exceed the cost of providing covered services; (4) requiring health care providers receive and retain the total computable amount of their Medicaid payment; and (5) make conforming changes to the SCHIP regulations.

Nevada does not take exception to these requirements, as written, and has tried to work with CMS to implement them. Numerous conference calls have occurred from March 2006 forward related to a State Plan Amendment (SPA) submitted by Nevada Medicaid in December 2005. While we have resolved many of the issues associated with coverage policy, CMS continues to have concerns with our payment methodologies, particularly for government health care providers. The limited guidance provided by CMS appears to not be supported by existing federal policies. In fact, the requirements that CMS has asked us to meet are inconsistent with these proposed regulations.

The proposed regulations require the Secretary to determine a reasonable method for identifying allowable Medicaid costs that incorporate not only OMB Circular A-87 cost principles but also Medicare cost principles when using certified public expenditures. Nevada submitted proposed language to CMS to establish the documentation requirements in compliance with OMB Circular A-87 and the Medicare cost principles. The language required the documentation of the provider's total Medicaid-allowable costs for delivering the medical services, including direct costs and indirect costs, based on an approved Public

Assistance Cost Allocation Plan (PACAP). The definitions used to determine direct and indirect costs mirrored the requirements in OMB Circular A-87. CMS did not approve them.

CMS responded that the documentation must contain the scope of costs and methods of cost allocation that have been approved by the CMS and not the Division of Cost Allocation (DCA). They indicated that the State must ensure that the direct services costs only includes what they define as allowable direct medical services costs (e.g., medical professional salaries/fringe benefits and medical supplies/equipment) and all other costs (e.g., supervision, clerical support, facility, operating, etc) must be identified as indirect costs. We believe this definition of direct and indirect costs is in direct conflict with the definitions and cost principles of OMB Circular A-87. The State brought DCA into the discussion with CMS, as the CMS directive was contrary to the federal law implemented by DCA. Our understanding is that CMS has been having discussions with DCA and they have yet to come to an agreement or provided the State with clear, consistent guidance.

As a result of the amount of time it has taken to provide the State with definitive guidance on cost documentation, the State is once again faced with termination of federal financial participation for essential services. This will have a tremendous adverse impact on important services to Medicaid recipients in Nevada and will leave the State, Medicaid recipients and their families, health care providers, advocates and legislators without a guaranteed source of revenue for critical services.

Payment for Graduate Medical Education (CMS 2279-P)

This proposed rule would exclude any reimbursement for graduate medical education under Medicaid. Over the next five state fiscal years, this change will result in a loss in revenue of approximately \$4.2 million dollars. The breakdown by year is as follows:

SFY	Total Computable	Federal Share	State General Funds
2008	\$820,429.00	\$434,499.20	\$385,929.80
2009	\$820,429.00	\$415,629.33	\$404,799.67
2010	\$820,429.00	\$415,629.33	\$404,799.67
2011	\$820,429.00	\$410,214.50	\$410,214.50
2012	\$820,429.00	\$410,214.50	\$410,214.50
TOTAL	\$4,102,145.00	\$2,086,186.86	\$2,015,958.14

Payment for Hospital Outpatient Services (CMS 2213-P)

The proposed regulation would make the following changes: 1) the methodology for determination of hospital outpatient upper payment limit (UPL) requiring the use of Medicare-based cost-to-charge and payment-to-charge ratios; 2) the treatment of GME costs in determination of UPL; and 3) the definition of Medicaid Outpatient Hospital Services to align with Medicare.

The impact of the above will be negative for Nevada hospital outpatient providers and to Medicaid recipients as a whole.

In addition, DSH payments will be reduced by restricting the types of costs which can be counted as “uncompensated care costs”.

UPL reimbursement will be reduced in proportion to the degree to which a facility’s Medicaid patient demographics differ from its Medicare patient demographics. This could be quite significant since Medicare’s recipient population is primarily elderly, whereas Medicaid’s recipient population is largely pediatric.

The more restricted definition of “outpatient services” may not only reduce hospital revenues by limiting/eliminating reimbursable services such as early, periodic screening, diagnosis and treatment for children, dental services for children; physician emergency department services; physical, occupational and speech therapies; outpatient clinical diagnostic laboratory services; ambulance services; durable medical equipment; and outpatient audiology services but create major access problems, as well. CMS seems to be taking the unsupported position that services no longer reimbursed through hospital outpatient departments will be provided by and paid for through other parts of the Medicaid program. In large swaths of rural Nevada, it is unclear that such services are available anywhere but from small, “safety net” hospital outpatient departments.

Because of the wide range of cost structures, case mixes and financial circumstances of Nevada providers and the complexity of the required calculations, it is not feasible to estimate the magnitude of the fiscal impact at this time

Provider Taxes (CMS 2275-P)

This proposed rule reduces the maximum level of allowable provider tax from 6 percent to 5.5 percent. Over the next five state fiscal years, this change will result in a loss in revenue of approximately \$10.6 million dollars. The breakdown by year is as follows:

SFY	Total Computable	Federal Share	State General Funds
2008	\$2,041,392.00	\$1,081,121.20	\$960,270.80
2009	\$2,081,966.00	\$1,054,723.98	\$1,027,242.02
2010	\$2,123,345.00	\$1,075,686.58	\$1,047,658.42
2011	\$2,165,548.00	\$1,082,774.00	\$1,082,774.00
2012	\$2,208,589.00	\$1,104,294.50	\$1,104,294.50
TOTAL	\$10,620,840.00	\$5,398,600.26	\$5,222,239.74

Coverage of Rehabilitation Services (CMS 2261-P)

The Division does not take issue with the majority of the proposed rehabilitation option regulations. However, our experience with CMS has been that they have not completed the research of other federally funded programs with regard to how far reaching, or not, their

perception is of "intrinsic elements", for example. The staff that our Division spoke with at central office CMS were unaware that TANF IV-E funds prohibited use of these dollars for "counseling" or clinical therapies associated with a child that is seriously emotionally disturbed. Rather, CMS has taken great liberties in making global assumptions about the overlap between the providers that interface with, and treat, recipients in child welfare that also have a diagnosis of a mental illness. The boundaries they are attempting to draw will leave no funding source, other than state general fund.

A final example of what we believe to be an inaccurate application of the proposed rehabilitation regulations by CMS is in their efforts to blatantly disallow states to bill for children in custody that may be receiving services while in foster care, i.e., therapeutic foster care. CMS perceives this to, yet again, be an intrinsic element of the child welfare program. The child welfare program does not have any responsibility or funding for children with mental illness. Medicaid is an appropriate payer of mental health services including therapeutic treatment that may occur regardless of who has parental custody. Again, CMS' efforts to draw these strong boundaries will leave no funding source other than state general fund resulting in what we anticipate to be increased unnecessary utilization of psychiatric residential treatment facilities (PRTF's) and inpatient hospitalization.

In our laborious discussions with CMS we are consistently troubled by their lack of knowledge or consideration for the states' requirements to comply with standardized coding language that providers must use in claiming for Medicaid payment. The best code descriptions for a number of mental health rehabilitation services include the reimbursement mechanism to be based on a per diem versus fifteen minute increments. CMS has been adamant that we will not be allowed to use "bundled" billing under state plan and that all services must be claimed using fifteen minute increments. The proposed regulations do not prohibit states from bundled rate methodologies or the use of "per diem" reimbursements. Nonetheless, CMS is enforcing this expectation.

The Division of Health Care Financing and Policy submitted a State Plan Amendment (SPA) in December 2005, under the rehabilitation option, which expanded the delivery of mental health services to be provided by licensed Marriage and Family Therapists and Licensed Clinical Social Workers. The state also diligently rewrote the existing behavioral health services to detail service definitions, provider qualification, and service limitations. Unfortunately, the Centers for Medicare and Medicaid Services (CMS) took that opportunity to apply a new approach to reviewing SPA's and reviewed all services that were on the "same page" as the behavioral health services. This same page review has jeopardized the continuum of behavioral health services and other non-behavioral health services. These services under the rehabilitation option include: Adult Day Health Care (ADHC), Comprehensive Outpatient Rehabilitation (COR), Partial Hospitalization Program (PHP), behavioral health outpatient services, and treatment homes.

Outpatient Behavioral Health Services

The outpatient behavioral health services section of the state plan has received two sunset delays from CMS. They have continually been delayed due to the cost allocation of public

expenditures. The third sunset date is due to expire June 31, 2008. There is no sense from CMS that these issues will be resolved prior to the expiration of this sunset.

COR, ADHC and PHP

The state was directed by CMS to move Adult Day Health Care, Comprehensive Outpatient Rehabilitation, and Partial Hospitalization Program under a new State Plan section for coverage via 1915(i) as created by the Deficit Reduction Act. Comprehensive Outpatient Rehabilitation and Partial Hospitalization Program were moved to 1915(i) based on CMS refusal to allow per diem rate methodologies under state plan. CMS informed the State that Adult Day Health Care could not be covered under the coverage section of the state plan as it was considered by them to be a waiver service. Nevada has had an approved state plan from CMS to provide Adult Day Health Care for several decades. The 1915(i) state plan has been subsequently put on hold by CMS pending resolution of approved cost allocation plans for the public entities receiving federal match for relevant services.

We have provided the following descriptions of these services as a part of this request:

Comprehensive Outpatient Rehabilitation Services (COR):

The (COR) services program provides coverage for community based comprehensive medical rehabilitation programs for eligible recipients under the rehabilitative services option of the Medicaid State Plan. Rehabilitation services are medically prescribed treatment for improving or restoring functions, which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury.

The population served by this program primarily consists of individuals who have been affected by traumatic brain injury. These are individuals who have undergone extensive rehabilitation following a brain injury and have often been unable to return home. Among other considerations due to the manifestations of traumatic brain injury, these individuals may not be safe if left unattended.

Currently, there is only one facility in Nevada that serves this population.

Nevada's Strategic Plan Accountability Committee for people with disabilities identifies brain injury as a group whose unique needs associated with cognitive and behavioral impairments set them apart from others with disabilities.

Should funding be eliminated, these recipients would need to be placed in neurobehavioral long-term care facilities, none of which exist in Nevada, or left to languish in nursing facilities which would violate the Olmstead decision.

Adult Day Health Care (ADHC):

Nevada currently has six adult day health care centers serving approximately 255 Medicaid recipients. These centers allow recipients to live with their families in the community.

These recipients must meet a nursing facility level of care to be eligible to attend ADHC. Therefore, should funding be eliminated, these recipients probably would not be able to remain living in the community and would have to be admitted to a nursing facility.

The per diem reimbursement rate of nursing facilities far exceeds the daily cost of adult day health care billed in fifteen minute increments. Most of these recipients would choose to remain living at home with their families and loved ones and not spend their remaining years residing in a nursing facility. Again, the State would be challenged for not complying with the Olmstead decision should these recipients unnecessarily reside in the restricted facility based environment.

Treatment Homes

Treatment home is a community-based service, which supports family-centered treatment and provides a living environment for children/adolescents or adults that is structured, therapeutic and staffed with trained individuals who, as part of the treatment home, provide rehabilitative mental health treatment services and/or interventions as prescribed in an individualized Treatment Plan. The need for the Treatment Home services is based on the Intensity of Needs Determination and must be prior authorized.

Over a two year period CMS has not been able to provide the State with a definitive answer regarding whether Treatment Home services would be allowable under the Rehabilitation Option. We have had face-to-face and telephonic meetings with CMS and have not made any progress. CMS has indicated to the State that they will not authorize this service to cover Therapeutic Foster Homes. We have consistently provided them with our regulatory description of this coverage benefit, as well as the provider qualifications. We have consistently advised them that the service described below is specific to children and adolescents with a serious emotional disturbance and who has custody of the child is an irrelevant issue. We believe that we are compliant with all federal laws and regulations related to the Medicaid comparability requirements. CMS has also indicated their refusal to allow this state plan benefit based on our reimbursement methodology. The HIPAA compliant code for this service specifies that reimbursement would be "per diem", not based on a fifteen minute increment of billing. CMS has not been able to resolve this issue and went so far as to advise us that if a child requires twenty-four care that they should be in an institution. Again, this would be contrary to the Olmstead decision. CMS asked us to put this service under 1915(i), as well. We do not know whether it would be approved under the Rehabilitation Option or 1915(i). As of this date, we are still awaiting a decision from CMS as to if this service would be covered or not. Should this service not be accepted by CMS for coverage under our program, we strongly believe that the majority of this young people will move from community based treatment home services with a daily rate of \$66 to costly, most restrictive treatment in PRTF's with an average daily rate of \$385.

This CMS action seems contrary to Congress' decision under the DRA to fund state grants that allowed for demonstration waivers for states to prove that it was cost effective to move children and adolescents out of PRTF's and into the community and results in improved treatment outcomes.

Over the next five state fiscal years, this change could result in a loss in revenue of approximately \$100 million dollars. The breakdown by year is as follows:

SFY	Total Computable	Federal Share	State General Funds
2008	\$17,973,935.03	\$9,518,995.99	\$8,454,939.04
2009	\$18,872,631.78	\$9,560,875.26	\$9,311,756.52
2010	\$19,816,263.37	\$10,038,919.02	\$9,777,344.35
2011	\$20,807,076.54	\$10,403,538.27	\$10,403,538.27
2012	\$21,847,430.37	\$10,923,715.18	\$10,923,715.18
TOTAL	\$99,317,337.09	\$50,446,043.73	\$48,871,293.36

Payments for Cost of School Administrative and Transportation Services (CMS 2287-P)

This proposed rule limits Medicaid reimbursement for school transportation and makes Medicaid payments no longer available for administrative activities performed by school employees. Over the next five state fiscal years, this change will result in a loss in revenue of approximately \$9 million dollars. The breakdown by year is as follows:

SFY	Total Computable	Federal Share	State General Fund
2008	\$1,653,203.91	\$826,601.95	\$826,601.95
2009	\$1,722,442.93	\$861,221.47	\$861,221.47
2010	\$1,794,581.81	\$897,290.90	\$897,290.90
2011	\$1,869,741.98	\$934,870.99	\$934,870.99
2012	\$1,948,049.99	\$974,025.00	\$974,025.00
TOTAL	\$8,988,020.62	\$4,494,010.31	\$4,494,010.31

This loss of revenue will affect three school districts in Nevada. Our largest two urban school districts (Clark and Washoe County) and one rural school district (Carson City). Approximately 62,000 students in the three districts were Medicaid eligible in State Fiscal year 2007. When the School District Administrative program is terminated, these children will no longer have access to school district staff for assistance with Medicaid enrollment or in accessing Medicaid benefits.

Targeted Case Management (CMS-2237-IFC)

Effective March 4, 2008, the TCM regulations will not allow the state to be reimbursed for TCM for Juvenile Justice or Child Protective Services. This represents approximately \$3.9 million for the State of Nevada. There are several outstanding questions regarding the interpretation of the regulation. The entire risk to the program is approximately \$28 million.

February 12, 2008

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If you have any additional questions, please contact John A. Liveratti, Chief, Compliance at 775-684-3606 or liveratt@dhefp.nv.gov. On behalf of the Medicaid recipients of Nevada, I would like to thank you and your Committee for investigating these actions.

Sincerely,



Charles Duarte,
Administrator

Cc: Honorable Tom Davis, Ranking Minority Member
Michael Willden, Director, Nevada Department of Health and Human Services
Mary Wherry, Deputy Administrator